For Human Services use only:

General Letter No. 8-AP-295
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

January 23, 2009

MATERNAL HEALTH CENTER MANUAL TRANSMITTAL NO. 09-1

ISSUED BY: Bureau of Long-Term Care, Division of Medical Services

SUBJECT: ***MATERNAL HEALTH CENTER MANUAL***, Table of Contents, page 1, new; Chapter III, *Provider Specific Policies*, Table of Contents (page 1), revised; pages 1, 2, and 5 through 29, revised; and the *Remittance Advice*, revised.

Maternal Health Center Chapter III is updated to:

- Remove references to case management. The Centers for Medicare and Medicaid Services published final regulations on targeted case management (CMS 2237) on March 3, 2008. Under these regulations, case management services are designed to address populations with a medical diagnosis, not a preventive care population. Due to this regulation, care coordination services will now be provided through an interagency agreement with the Iowa Department of Public Health, not as a component of Medicaid maternal health center services.
- End date two procedure codes for fluoride, as fluoride varnish is the only code needed.
- Correct the age references for dental codes.
- Update instructions for the *Health Insurance Claim Form*, CMS-1500.
- Update the *Remittance Advice* sample and instructions.

Date Effective

February 1, 2009

Material Superseded

Remove the following pages from ***MATERNAL HEALTH CENTER MANUAL*** and destroy them:

Page	Date
Chapter III	
Contents (p. 1)	October 1, 2007
1, 2, 5-26	October 1, 2007
RA-1500	6/21/97
27-30	October 1, 2007

Additional Information

The updated provider manual containing the revised pages will be available by February 1, 2009, at: **www.ime.state.ia.us/providers**

Until then, this letter and the revised pages will be available at:

http://www.dhs.iowa.gov/policyanalysis/PolicyManualPages/medprovgl.htm

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise Provider Services Unit.

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. MATERNAL HEALTH CENTERS ELIGIBLE TO PARTICIPATE

A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services. Team members must be employed by or under contract with the center. The team must have at least:

- A physician.
- A registered nurse.
- A licensed dietitian.
- A person with at least a bachelor's degree social work, counseling, sociology, or psychology.

The prenatal and postpartum care shall be in accordance with the latest edition of the Standards for Obstetric-Gynecologic Services published by the American College of Obstetricians and Gynecologists.

Medical services shall be:

- Provided under the supervision of a physician.
- Provided by:
  - A physician,
  - A physician assistant, or
  - A nurse practitioner.

These people may be employed by or under contract to the center. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of their profession, as defined by the Code of Iowa. Provide trimester and postpartum reports to the referring physician.

B. COVERAGE OF SERVICES

Services shall be provided as medically necessary. Payment will be made for:

- Prenatal risk assessment.
- Prenatal and postpartum medical care.
- Health education services for patients who are not determined high-risk.
- "Enhanced" (more intense) prenatal services for patients determined high-risk.

Enhanced services may include:

- Additional health education,
- Nutrition counseling,
- Social services,
- Additional care coordination, and
- A Postpartum home visit.

1. Prenatal Risk Assessment

Determine risk for pregnant Medicaid members upon entry into care using form 470-2942, *Medicaid Prenatal Risk Assessment*. To view a sample of this form on line, click here.

When a low-risk pregnancy is reflected, complete a second determination at approximately 28 weeks of care or when an increase in the pregnant woman's risk status is indicated.

The Iowa Departments of Human Services and Public Health have jointly developed the *Medicaid Prenatal Risk Assessment* to help the clinician determine which pregnant clients are in need of supplementary services to complement and support routine medical prenatal care.

The form categorizes the risk factors and assigns a score value related to the seriousness of the risk. In individual cases, the clinician may determine that the value the form assigns is not appropriate and may choose a lesser value.

To determine a woman's risk status during the current pregnancy, add the total score value on the left side and either the B_1 column (initial visit score value) or the B_2 column (re-screen visit between 24-28 weeks gestation score value) to obtain the total score. A total score of 10 meets the criteria for high risk on this assessment.

When a high-risk pregnancy is reflected, inform the woman and provide enhanced services. (See Enhanced Services to High-Risk Women.) Give a copy of the *Medicaid Prenatal Risk Assessment* to the agency providing enhanced services and keep a copy in the patient's medical records.

- Post partum home visits:

  A registered nurse shall provide a postpartum home visit within two weeks of the child's discharge from the hospital (ideally in the first week). This visit shall include:

  - An assessment of the mother's health status.
  - Discussion of physical and emotional changes postpartum, including relationships, sexual changes, additional stress, nutritional needs, physical activity, and grief support for unhealthy outcome.
  - Family planning.
  - A review of parenting skills, including nurturing, meeting infant needs, bonding, and parenting of a sick or preterm infant.
  - An assessment of the infant's health.
  - A review of infant care, including feeding and nutritional needs, breast-feeding support, recognition of illness, accident prevention, immunizations, and well-child care.
  - Identification and referral to community resources as needed.

- Transportation to receive prenatal and postpartum services that is not otherwise payable under the Medicaid program.
- Dental hygiene services within the scope of practice defined by the Iowa Board of Dental Examiners for dental hygienists providing services under public health supervision.

Encourage clients to enroll in community prenatal classes.

Care coordination related to a direct service is considered part of the direct service. Activities must be considered a part of the direct service if they are included in the pre and post visit services. This direct care related activity should not be considered a care coordination service.

NOTE: Activities that are considered integral to, or an extension of, the specific covered service are included in the rate set for the **direct service**. Therefore they should not be claimed as another service. For example, when an agency provides a medical service, the practitioner should not bill separately for the cost of a referral. These activities are properly paid for as part of the medical service."

3. Enhanced Services to High-Risk Women

Additional services are available to women determined to have high-risk pregnancies. The services included in the Medicaid enhanced services for pregnant women are recommended in a 1989 report of the United States Public Health Services Expert Panel on the Content of Prenatal Care, *Caring for the Future: The Content of Prenatal Care*.

National studies have shown that low-income women who receive these services along with medical prenatal care have better birth outcomes. This package of services is aimed at promoting improved birth outcomes for Medicaid-eligible pregnant women in Iowa.

Maternal health centers that provide enhanced services work with physicians to provide services to higher risk pregnant women. This process allows patients determined to be at high risk to access additional services that Medicaid does not provide under other circumstances. It is expected that the primary medical care provider will continue to provide the medical care.

The enhanced services include:

- Health education services
- Nutrition services
- Psychosocial services

a. Health Education

A registered nurse shall provide health education services. In addition to the education services listed earlier, education on the following topics should be provided as appropriate:

- High-risk medical conditions related to pregnancy, such as PIH, preterm labor, vaginal bleeding, gestational diabetes, chronic urinary conditions, genetic disorders, and anemia.
- Chronic medical conditions, such as diabetes, epilepsy, cardiac disease, sickle cell disease, and hypertension.
- Other medical conditions, such as HIV, hepatitis, and sexually transmitted diseases.
- Smoking cessation. Refer to Quitline Iowa at 800-784-8669 or on the web at http://www.quitlineiowa.org/.

- Alcohol use.
- Drug use.
- Education on environmental and occupational hazards.
- High-risk sexual behavior.

You may make referrals to:

- Programs for stopping smoking or the use of alcohol or drugs.
- Psychosocial services for high-risk parenting issues or home situations, stress management, communication skills and resources, or self esteem.

b. Nutrition Services

A licensed dietitian shall provide nutrition services. Nutrition assessment and counseling shall include:

- Initial assessment of nutritional risk based on height, current and pre-pregnancy weight status, laboratory data, clinical data, and self-reported dietary information. Discuss the client's attitude about breastfeeding.
- At least one follow-up nutritional assessment, as evidenced by dietary information, adequacy of weight gain, measures to assess uterine and fetal growth, laboratory data, and clinical data.
- Development of an individualized nutritional care plan.
- Referral to food assistance programs, if indicated.
- Nutritional interventions:
  - Nutritional requirements of pregnancy as linked to fetal growth and development.
  - Recommended dietary allowances for pregnancy.
  - Appropriate weight gain.
  - Vitamin and iron supplements.
  - Information to make an informed infant feeding decision.
  - Education to prepare for the proposed feeding method and the support services available for the mother.
  - Infant nutritional needs and feeding practices.

c. Psychosocial Services

Psychosocial assessment and counseling shall include:

- A psychosocial needs assessment including a profile of the mother's:
  - Demographic factors,
  - Mental and physical health history and concerns,
  - Adjustment to pregnancy and future parenting, and
  - Environmental needs.
- A profile of the mother's family composition, patterns of functioning, and support systems.
- An assessment-based plan of care.
- Risk tracking.
- Counseling and anticipatory guidance as appropriate.
- Referral and follow-up services.

Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies.

D. BASIS OF PAYMENT FOR MATERNAL HEALTH CENTERS

Maternal health centers are reimbursed on a fee-for-service basis. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Bill all procedures in whole units of service. For some codes, 15 minutes equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.

E. RECORDS

The documentation for each "patient encounter" shall include the following (when appropriate):

- Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identity of the observer.
- Specific procedures or treatments performed.
- Medications or other supplies.
- Member's progress, response to and changes in treatment, and revision of diagnosis.
- Information necessary to support each item of service reported on the Medicaid claim form:
  - Date of service.
  - Place of service.
  - Name of member.
  - Name of provider agency and person providing the service.
  - Nature, content, or units of service.
  - A record of the time to support the units billed. (Time include AM/PM)

The requirements for documenting medical transportation services include the following:

- Date of service
- Member's name
- Address of where member was picked up
- Destination (medical provider's name and address)
- Invoice of cost
- Mileage if the transportation is paid per mile

Providers of service shall maintain fiscal records in support of each item of service for which a charge is made to the program. The fiscal record does not constitute a clinical record.

Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment of Medicaid payment.

As a condition of accepting Medicaid payment for services, providers are required to provide the Iowa Medicaid program access to members' medical records when requested. Providers shall make the medical and fiscal records available to the Department or its duly authorized representative on request.

F. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). Services or charges cannot be fragmented for each procedure code billed. Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied.

1. Maternity Care

Code	Description
59425	Antepartum care only; 4 to 6 visits
59426	Antepartum care only; 7 or more visits
99420	Completion of *Medicaid Prenatal Risk Assessment*, form 470-2942
S9465	Diabetic management program, dietitian visit
90471	Immunization administration
90472	Immunization administration, each additional vaccine
H0046	Mental health services, not otherwise specified, per encounter
S9123	Nursing visit in the home, per hour
S9470	Nutrition counseling dietitian visit
59025	Fetal non-stress test
59430	Postpartum care only (separate procedure)
H1003	Prenatal care, at risk enhanced service education, 15-minute unit
S9127	Social work visit in the home (encounter code)
81025	Urine pregnancy test, by visual color comparison

New Patient

Code	Description
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: ♦ A problem-focused history; ♦ A problem focused examination; and ♦ Straightforward medical decision-making. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: ♦ An expanded problem-focused history; ♦ An expanded problem-focused examination; and ♦ Straightforward medical decision-making. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: ♦ A detailed history; ♦ A detailed examination; and ♦ Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems) and the patient's and family's needs. Usually, the presenting problems are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient or family.

Code	Description
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: ♦ A comprehensive history; ♦ A comprehensive examination; and ♦ Medical decision making of moderate complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: ♦ A comprehensive history; ♦ A comprehensive examination; and ♦ Medical decision making of high complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient or family.

Established Patient

Code	Description
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: ♦ a problem-focused history; ♦ a problem-focused examination; ♦ straightforward medical decision-making. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: ♦ an expanded problem-focused history; ♦ an expanded problem-focused examination; ♦ medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the presenting problems are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient or family.

Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: ♦ a detailed history; ♦ a detailed examination; ♦ medical decision making of moderate complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: ♦ a comprehensive history; ♦ a comprehensive examination; ♦ medical decision making of high complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient or family.

Do not submit a copy of the *Medicaid Prenatal Risk Assessment*, 470-2942. Maintain the form in the medical file.

2. Injections

Immunizations are usually given in conjunction with a medical service. Immunization procedures include the supply of related materials. Bill the vaccine administration codes in addition to the CPT code.

Provide immunizations under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are:

Code	Description
90633	Hepatitis A, pediatric/adolescent (2-dose schedule)
90649	Human Papilloma virus (HPV)
90658	Influenza virus vaccine, age 3 years and older
90707	Measles, mumps, and rubella virus vaccine
90710	Measles, mumps, rubella, varicella (MMRV)
90714	Tetanus and diphtheria toxoids (TD), adsorbed, preservative free, age 7 years and older
90715	Tetanus, diphtheria toxoids and acellular pertussis (TDaP), age 7 years and older
90716	Varicella vaccine
90718	Tetanus and diphtheria toxoids adsorbed, 7 years or older (TD)
90734	Meningococcal conjugate vaccine
90743	Hepatitis B vaccine; adolescent (two-dose schedule), for intramuscular use
90744	Hepatitis B vaccine; pediatric/adolescent dosage (three-dose schedule), for intramuscular use
90746	Hepatitis B vaccine; age 20 years and older

For VFC vaccine, bill code 90471 and 90472 for vaccine administration in addition to the CPT code. Charge your usual and customary charge for the administration 90471 and 90472. The charges in box 24F should be "0" for the vaccine.

NOTE: 90473 (immunization administration by oral or nasal route) cannot be used with 90471.

When a member receives a vaccine outside of VFC coverage, Medicaid will provide reimbursement for the vaccine. Codes for other injections:

Code	Description
90782	Injection of medication
J2790	Rhogam, RHO D immune globulin

3. Local Transportation

In the diagnosis code area of the claim form, use diagnosis code V68.9.

Code	Description	Unit
A0080	Non-emergency transportation; vehicle provided by volunteer (individual or organization), with no vested interest	Per round trip
A0100	Non-emergency transportation; taxi	Per round trip
A0110	Non-emergency transportation; bus, intra or interstate carrier	Per round trip
A0130	Non-emergency transportation; wheelchair van	Per round trip
A0160	Non-emergency transportation, by caseworker or social worker	Per round trip
A0170	Transportation; parking fees, tolls, other	

4. Oral Health Services

In the diagnosis area of the claim form, use diagnosis code 528.9. NOTE: For dental coding, "child" means age 12 and younger and "adult" means age 13 and older.

Code	Procedure	Comment
D0150	Initial screening evaluation	
D0120	Screening evaluation (periodic)	Once every six months
D1110	Adult prophylaxis	
D1120	Child prophylaxis	
D1206	Topical fluoride varnish	
D1310	Nutritional counseling for the control and prevention of oral disease	15-minute unit
D1320	Tobacco counseling for the control and prevention of oral disease	15-minute unit
D1330	Oral hygiene instructions (home care, tooth brushing, flossing and special hygiene aids)	15-minute unit
D1351	Sealant, per tooth	

G. CLAIM FORMS

Bill for maternal health center services on the *Health Insurance Claim Form*, CMS-1500. To view a sample of this form on line, click here.

Providers interested in billing electronically can contact EDISS (Electronic Data Interchange Support Services) at 800-967-7902 or by e-mail at edi@noridian.com.

Electronic media claim (EMC) submitters should also refer to your EMC specifications for claim completion instructions.

1. Instructions for Completing the CMS-1500 Claim Form

The table below follows the CMS-1500 claim form by field number and name, and gives a brief description of the information to be entered and whether providing information in that field is required, optional, or conditional of the individual member's situation.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**REQUIRED.** Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED.** Enter the Medicaid member's Medicaid number, found on the *Medical Assistance Eligibility Card*. The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	**REQUIRED.** Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	**OPTIONAL.** Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
4.	INSURED'S NAME	**OPTIONAL.** For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	**OPTIONAL.** Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**OPTIONAL.** For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	**OPTIONAL.** For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	**REQUIRED, IF KNOWN.** Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	**SITUATIONAL.** Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	**REQUIRED, IF KNOWN.** Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL.** No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER	**OPTIONAL.** For Medicaid purposes, the "insured" is always the same as the patient.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**REQUIRED.** If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check **both** "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. NOTE: Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL.** No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL.** No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	**SITUATIONAL.** Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	**SITUATIONAL.** Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL.** No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL.** Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the patient to your office.
17a.		**LEAVE BLANK**. The claim will be returned if any information is entered in this field.
17b.	NPI	**SITUATIONAL.** If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider. If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL.** No entry required.
19.	RESERVED FOR LOCAL USE	**OPTIONAL.** No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL.** No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED.** Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary, 2-secondary, 3-tertiary, and 4-quaternary), to a maximum of four diagnoses. Do **not** enter descriptions If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL.** If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.
24. A	DATE(S) OF SERVICE/NDC TOP SHADED PORTION LOWER PORTION	 **SITUATIONAL.** Required for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). No spaces or symbols should be used in reporting this information. **REQUIRED.** Enter the month, day, and year under both the "From" and "To" categories for each procedure, service or supply. If the "From-To" dates span more than one calendar month, enter each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED.** Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	**OPTIONAL.** No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED.** Enter the codes for each of the dates of service. **Do not** list services for which no fees were charged. Do **not** enter the description. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	**REQUIRED.** Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED.** Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	**REQUIRED.** Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total **minutes** of general anesthesia.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL.** Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	**LEAVE BLANK**. The claim will be returned if any information is entered in this field.
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	**LEAVE BLANK** **REQUIRED.** Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL.** No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE.** Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT?	**OPTIONAL.** No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED.** Enter the total of the line-item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**SITUATIONAL.** Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	**REQUIRED.** Enter the amount of total charges less the amount entered in field 29.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED.** Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of the claim form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**OPTIONAL.** Enter the name and address associated with the rendering provider.
32a.	NPI	**OPTIONAL.** Enter the NPI of the facility where services were rendered.
32b.		**LEAVE BLANK**. The claim will be returned if any information is entered in this field.
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED.** Enter the complete name and address of the billing provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered. The address **must** contain the ZIP code associated with the billing provider's NPI. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, access imeservices.org.
33a.	NPI	**REQUIRED.** Enter the ten-digit NPI of the billing provider.
33b.		**REQUIRED.** Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code, access imeservices.org.

2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- **Staple** the additional information to form 470-3969, *Claim Attachment Control*. (To view a sample of this form on line, click here.)
- Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- **Do not** attach a paper claim.
- Mail the *Claim Attachment Control* with attachments to:

  Iowa Medicaid Enterprise
  PO Box 150001
  Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

H. REMITTANCE ADVICE

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follow. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

IAMC8000-R001 (CP-O-12)
AS OF 10/22/07

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 10/19/07

R E M I T T A N C E A D V I C E

TO: (1) R.A. NO.: 3(2)6 WARR NO.: 9(3)9 DATE PAID: 10/22/07 (4) PROV. NUMBER: (5) PAGE: (6) 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* * * CLAIM TYPE: HCFA 1500 (7)								* * * CLAIM STATUS: PAID (8)					
ORIGINAL CLAIMS: (9)			(11)			(12)	(13)	(14)	(15)	(16)			(17)
		(10)	3-07290-00-015-0941-00		(21)	172.00	0.00	85.07	1.00				000 000
		(18) 01	(19) 10/04/07	99242 (20)	1	172.00	(22)	85.07 (24)	1.00 (25)	(26)		F	000 000
							(23)						
			3-07292-00-009-0053-00			69.00	0.00	32.36	0.00	(27)			000 000
		01	07/06/07	99212	1	69.00		32.36	0.00			F	000 000
			3-07288-00-010-0484-00			298.00	0.00	145.03	0.00				000 000
		01	07/11/07	99212 25	1	69.00		32.36	0.00			F	000 000
		02	07/11/07	29405	1	197.00		112.67	0.00			F	000 000
		03	07/11/07	A4590	1	32.00		0.00	0.00			K	177 000
			0-07281-22-009-0270-00			128.00	0.00	71.46	0.00				000 000
		01	06/14/07	20550	1	122.00		68.06	0.00			F	000 000
		02	06/14/07	J3301	2	6.00		3.40	0.00			F	000 000
4 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..						667.00	0.00	333.92	1.00				

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 2

**** PATIENT NAME **** LAST	FIRST	MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* * * CLAIM TYPE: HCFA 1500									* * * CLAIM STATUS: DENIED					
ORIGINAL CLAIMS:														
				3-07289-00-011-0880-00			69.00	0.00	0.00	0.00			499	000
			01	07/12/07	99212	1	69.00		0.00	0.00			K 000	000
1 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..							69.00	0.00	0.00	0.00				

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 3

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REMITTANCE T O T A L S					
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	4	---------	667.00	333.92
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	1	---------	69.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	---------	0.00	0.00
AMOUNT OF CHECK:					333.92

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:

29

177 THE PROCEDURE/SERVICE BILLED HAS BEEN DETERMINED TO BE NONCOVERED FOR THE DATE OF SERVICE SHOWN ON THE CLAIM. 1

499 INVALID OR MISSING MEDIPASS REFERRAL FOR RECIPIENT. 1

2. Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click here.

NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's Medicaid (Title XIX) number.
6.	Page:	*Remittance Advice* page number.
7.	Claim Type:	Type of claim used to bill Medicaid.
8.	Claim Status:	Status of following claims: • **Paid**. Claims for which reimbursement is being made. • **Denied**. Claims for which no reimbursement is being made. • **Suspended**. Claims in process. These claims have not yet been paid or denied.
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.

NO.	FIELD NAME	DESCRIPTION
15.	Copay Amt.	Total amount of member copayment deducted from this claim.
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.
27.	S	Allowed charge source code: **B** Billed charge **F** Fee schedule **M** Manually priced **N** Provider charge rate **P** Group therapy **Q** EPSDT total screen over 17 years **R** EPSDT total under 18 years **S** EPSDT partial over 17 years **T** EPSDT partial under 18 years **U** Gynecology fee **V** Obstetrics fee **W** Child fee

NO.	FIELD NAME	DESCRIPTION
28.	Remittance totals	(Found at the end of the *Remittance Advice*): • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of denied original claims and the amount billed by the provider. • Number of denied adjusted claims and the amount billed by the provider. • Number of pended claims (in process) and the amount billed by the provider. • Amount of the check (warrant) written to pay these claims.
29.	Description of EOB code	Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.